

with a sufficient number and range of providers to meet the access standards described in section 1852(d)(1) of the Act.

(B) [Reserved]

(iii) A combination of paragraphs (a)(2)(i) and (a)(2)(ii) of this section.

(3) For plan year 2011 and subsequent plan years, an MA organization that offers an MA private fee-for-service plan (other than a plan described in section 1857(i)(1) or (2) of the Act) that is operating in a network area (as defined in paragraph (a)(3)(i) of this section) meets the requirement in paragraph (a)(1) of this section only if the MA organization has contracts or agreements with providers in accordance with paragraph (a)(2)(ii)(A) of this section.

(i) Network area is defined, for a given plan year, as the area that the Secretary identifies in the announcement of the risk and other factors to be used in adjusting MA capitation rates for each MA payment area for the previous plan year as having at least 2 network-based plans (as defined in paragraph (a)(3)(ii) of this section) with enrollment as of the first day of the year in which the announcement is made.

(ii) Network-based plan is defined as a coordinated care plan as described in § 422.4(a)(1)(ii), a network-based MSA plan, or a section 1876 reasonable cost plan. A network-based plan excludes a MA regional plan that meets access requirements substantially through the authority of § 422.112(a)(1)(ii) instead of written contracts.

(4) For plan year 2011 and subsequent plan years, an MA organization that offers an MA private fee-for-service plan that is described in section 1857(i)(1) or (2) of the Act meets the requirement in paragraph (a)(1) of this section only if the MA organization has contracts or agreements with providers in accordance with paragraph (a)(2)(ii)(A) of this section.

(b) *Freedom of choice.* MA fee-for-service plans must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and Part B and agrees to provide services under the terms of the plan.

(c) *Contracted network.* Private fee-for-service plans that meet network

adequacy requirements for a category of health care professional or provider by meeting the requirements in paragraph (a)(2)(ii) of this section may provide for a higher beneficiary copayment in the case of health care professionals or providers of that same category who do not have contracts or agreements to provide covered services under the terms of the plan.

[63 FR 35077, June 26, 1998, as amended at 70 FR 4723, Jan. 28, 2005; 73 FR 54249, Sept. 18, 2008]

§ 422.118 Confidentiality and accuracy of enrollee records.

For any medical records or other health and enrollment information it maintains with respect to enrollees, an MA organization must establish procedures to do the following:

(a) Abide by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information. The MA organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify—

(1) For what purposes the information will be used within the organization; and

(2) To whom and for what purposes it will disclose the information outside the organization.

(b) Ensure that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

(c) Maintain the records and information in an accurate and timely manner.

(d) Ensure timely access by enrollees to the records and information that pertain to them.

[65 FR 40323, June 29, 2000]

§ 422.128 Information on advance directives.

(a) Each MA organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. For purposes of this part, *advance directive* has the meaning given the term in § 489.100 of this chapter.

(b) An MA organization must maintain written policies and procedures

concerning advance directives with respect to all adult individuals receiving medical care by or through the MA organization.

(1) An MA organization must provide written information to those individuals with respect to the following:

(i) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.

(ii) The MA organization's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the MA organization cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

(A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.

(B) Identify the state legal authority permitting such objection.

(C) Describe the range of medical conditions or procedures affected by the conscience objection.

(D) Provide the information specified in paragraph (a)(1) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the MA organization may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The MA organization is

not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

(E) Document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.

(F) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

(G) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives.

(H) Provide for education of staff concerning its policies and procedures on advance directives.

(I) Provide for community education regarding advance directives that may include material required in paragraph (a)(1)(i) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the MA organization. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An MA organization must be able to document its community education efforts.

(2) The MA organization—

(i) Is not required to provide care that conflicts with an advance directive; and

(ii) Is not required to implement an advance directive if, as a matter of conscience, the MA organization cannot implement an advance directive and State law allows any health care provider or any agent of the provider to conscientiously object.

(3) The MA organization must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with

the State survey and certification agency.

§ 422.132 Protection against liability and loss of benefits.

Enrollees of MA organizations are entitled to the protections specified in § 422.504(g).

[63 FR 35077, June 26, 1998, as amended at 70 FR 52026, Sept. 1, 2005]

§ 422.133 Return to home skilled nursing facility.

(a) *General rule.* MA plans must provide coverage of posthospital extended care services to Medicare enrollees through a home skilled nursing facility if the enrollee elects to receive the coverage through the home skilled nursing facility, and if the home skilled nursing facility either has a contract with the MA organization or agrees to accept substantially similar payment under the same terms and conditions that apply to similar skilled nursing facilities that contract with the MA organization.

(b) *Definitions.* In this subpart, *home skilled nursing facility* means—

(1) The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of posthospital extended care services;

(2) A skilled nursing facility that is providing posthospital extended care services through a continuing care retirement community in which the MA plan enrollee was a resident at the time of admission to the hospital. A continuing care retirement community is an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period; or

(3) The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from the hospital.

(4) If an MA organization elects to furnish SNF care in the absence of a prior qualifying hospital stay under § 422.101(c), then that SNF care is also subject to the home skilled nursing facility rules in this section. In applying the provisions of this section to coverage under this paragraph, references

to a hospitalization, or discharge from a hospital, are deemed to refer to wherever the enrollee resides immediately before admission for extended care services.

(c) *Coverage no less favorable.* The posthospital extended care scope of services, cost-sharing, and access to coverage provided by the home skilled nursing facility must be no less favorable to the enrollee than posthospital extended care services coverage that would be provided to the enrollee by a skilled nursing facility that would be otherwise covered under the MA plan.

(d) *Exceptions.* The requirement to allow an MA plan enrollee to elect to return to the home skilled nursing facility for posthospital extended care services after discharge from the hospital does not do the following:

(1) Require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under Part A for Medicare beneficiaries not enrolled in the MA plan.

(2) Prevent a skilled nursing facility from refusing to accept, or imposing conditions on the acceptance of, an enrollee for the receipt of posthospital extended care services.

[68 FR 50857, Aug. 22, 2003, as amended at 70 FR 4723, Jan. 28, 2005]

Subpart D—Quality Improvement

SOURCE: 63 FR 35082, June 26, 1998, unless otherwise noted.

§ 422.152 Quality improvement program.

(a) *General rule.* Each MA organization that offers one or more MA plans must have, for each of those plans, an ongoing quality improvement program that meets applicable requirements of this section for the service it furnishes to its MA enrollees. As part of its ongoing quality improvement program, a plan must—

(1) Have a chronic care improvement program that meets the requirements of paragraph (c) of this section concerning elements of a chronic care program and addresses populations identified by CMS based on a review of current quality performance;

(2) Conduct quality improvement projects that can be expected to have a